PART 1:
INTRODUCTION

Introduction

The Face of Homelessness

The Urgent Problem

During the 1980's, the United States experienced the largest increase of homelessness in recent history. Numerous reports and studies confirm what is painfully obvious as we walk down any one of our city streets in America: homelessness is a pervasive problem throughout this country. And contrary to our notion that homelessness is just confined to our urban areas, it is a problem that now plagues communities where in the past it would seem unthinkable — our Nation's rural communities.

How many homeless people are there? The exact number of individuals living without stable housing in this country is almost impossible to know. But according to a 2001 study, *Helping America's Homeless,* it is estimated that 842,000 people were homeless in a given week. In the same year, an estimated 3.5 million people were homeless over the course of a year. A 1995 study reports that over a five-year period two to three percent of the U.S. population (five to eight million people) will experience at least one night of homelessness. While the exact number is uncertain, it is a general acknowledgment that homelessness in the United States is steadily on the rise.

Why are people homeless? This is a difficult question to answer; however, there are a variety of conditions that interact to contribute to an individual or family becoming homeless. Underlying all homelessness are the conditions of poverty: inadequate income and the lack of affordable housing. Inadequate income may be due to unemployment (either because of market conditions, lack of skills or an inability to work due to disability), or underemployment, as a result of the trend over the last two decades from well-paid manufacturing jobs to minimum-wage service sector jobs. Even for those who have jobs, the decline or stagnation of wages has meant that employment is not necessarily a relief from poverty.

For those unable to work, income or assistance in the form of public benefits has decreased significantly over the past two decades. This has particularly affected families — considered to be the fastest growing subgroup of people experiencing homelessness. It is anticipated that this downward trend will continue even more drastically as welfare programs are shifted from the Federal level to State authority. Additionally, people with little or no income find it harder to find affordable housing. Over the past two decades, there has been a significant decrease in the number of affordable housing units. Between 1973 and 1993, over two million low-rent housing units disappeared from the market. At the same time, the number of low-income renters increased by nearly five million.

In addition to poverty, there are also personal factors that can increase an individual or family's vulnerability to becoming homeless. Some of these characteristics include acute and chronic physical problems or disabilities, mental illnesses (both chronic and acute), substance abuse problems, domestic violence, history of abuse or neglect (as a child), or any combination of the above.

The thousands of men, women, and children living in homelessness are challenged at nearly every turn in their daily struggle to survive. Whether concentrating on finding a meal or a place to sleep each night, these disenfranchised individuals struggle to maneuver through a series of support systems, always hoping that they will not fall through the cracks.

The Comprehensive Response

In 1987, the Stewart B. McKinney Homeless Assistance Act, Public Law 100-77, was enacted to provide relief to the Nation's rapidly increasing number of homeless individuals. The intent of the Act was to provide funding for emergency food and shelter, education, and transitional and permanent housing, as well as to address the multitude of health problems faced by homeless individuals. As a result, Title VI of the McKinney Act added Section 340 to the Public Health Service Act, authorizing the Secretary of Health and Human Services (HHS), acting through the Health Resources and Services Administration (HRSA), to award grants for the provision of health care to homeless individuals. The addition of Section 340 to the PHS Act established the Health Care for Homeless (HCH) Program, the only Federal program with the sole responsibility of addressing the critical primary health care needs of homeless individuals. In 1996, the Health Care for the Homeless program was re-authorized under Section 330(h) of the Health Centers Consolidation Act, which amended the PHS Act by consolidating these programs with other community-based health programs.

The HCH Program was modeled after a successful four-year demonstration program operated in 19 cities throughout the country by the Robert Wood Johnson Foundation (RWJ) and the Pew Charitable Trust (PCT). The RWJ/PCT program emphasized a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and client advocacy. Particular emphasis was placed on coordinating efforts with other community health providers and social service agencies.

What the RWJ/PCT projects confirmed was, unfortunately, not a surprise: the health status of homeless people is far worse than that of the rest of the general population. The program also demonstrated that homeless people, who have generally tended to fall through the cracks of the traditional health care system, could be reached by programs emphasizing outreach and offering targeted, flexible services where homeless people can be found, including shelters and soup kitchens. Building on the operational experience of the national demonstration, the HCH Program has made it possible for other communities to make primary care and substance abuse services accessible to homeless families and individuals throughout the United States. There is a critical need for programs that are specifically targeted to provide health care to this underserved segment of society. Although homeless programs have much in common with other community-based providers of care to underserved populations, it is also markedly different. Homeless individuals suffer from health care problems at more than double the rate of individuals with stable housing. This phenomenon is exacerbated by the multiple barriers that homeless people experience in trying to access health care. Homeless people frequently find that a lack of transportation and the limited hours of service present barriers to accessing mainstream service. When homeless individuals do attempt to access services, they routinely do not have the necessary financial resources (health insurance, Medicaid, etc.) to pay for the care. Additionally, many homeless individuals have significant mental health and/or substance abuse problems. As a result, they become increasingly disenfranchised from mainstream services and are frequently distrustful of traditional health care and social service systems.

The HCH program recognizes the complex needs of homeless people, and encourages participating programs to integrate both health and social services into individual care plans. HCH grantees strive to provide a coordinated, comprehensive approach to the care they provide their homeless clients, and in such a way that welcomes them as patients. Specifically, HCH programs:

- Provide for primary health care and substance abuse services at locations accessible to homeless people;

- Provide for emergency care with referrals to hospitals for in-patient care services and/or to needed mental health services; and

- Provide for outreach services to access difficult to reach homeless persons, and for aid in establishing eligibility for entitlement programs and housing.

To increase access to services and resources for homeless people, HCH grantees are encouraged to develop, or actively participate in, local coalitions of health care providers and social service agencies. These collaborations help ensure the adequate and appropriate delivery of services for persons who are homeless. This involvement has been important in identifying community resources for the provision of shelter, food, clothing, employment training, and job placement for homeless individuals. HCH grantees obtain commitments from their communities for social service support and seek financial contributions to expand the scope of their programs.

The goal of the HCH program is to improve health status and outcomes for homeless individuals and families by improving access to primary health care and substance abuse services. Access is improved through outreach, case management, and linkages to services such as mental health, housing, benefits, and other critical supports. HCH providers must seek ways to create new approaches to deliver comprehensive care, unite providers through collaboration, decrease fragmentation of human services, and advocate on behalf of homeless people.

The Appropriation

Within four months of the signing of the McKinney Act in 1987, the Health Resources and Services Administration awarded 109 grants to initiate HCH projects in 43 states, the District of Columbia, and the Commonwealth of Puerto Rico. The first grantees received their initial awards in 1988, and became fully operational HCH projects in 1989.

For FY 2002, nearly $116 million was appropriated by Congress for the Health Care for the Homeless program. This enabled the HCH program to continue funding existing grantees and to add 10 new grantees for a total of 154 grantees in all 50 states, the District of Columbia, and the Commonwealth of Puerto Rico. As evidenced in Table 1, Federal funding has continued to increase since 1990 to assist local programs in meeting the health care needs of the growing number of homeless individuals.

Table 1. Federal Assistance for HCH Programs

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Year	Appropriations (In millions)
1990	$35.7
1991	$51.0
1992	$56.0
1993	$58.0
1994	$63.0
1995	$65.4
1996	$65.4
1997	$69.4
1998	$71.3
1999	$80.0
2000	$88.0
2001	$101.00
2002	$116.00

The Homeless Children's Program

In 1992, the Outreach and Primary Health Services for Homeless Children Program (HCHC) was established as an amendment to the Stewart B. McKinney Homeless Assistance Act, which amended the Public Health Service Act to include Section 340(s). This program, commonly called the Homeless Children's Program, is now included under section 330(h) of the Health Centers Consolidation Act of 1996.

Homeless children experience many difficulties, such as inadequate health care, food, clothing, education, and of course, a lack of housing. Hunger and poor nutrition are common experiences for homeless children, and inadequate diets contribute to unhealthy growth and development. Due to the transient nature of homeless families, children tend to fall behind in school and oftentimes experience developmental delays.

The critical component of the Homeless Children's Program is to create a "medical home" to ensure the provision of primary health care and outreach services to homeless children, and to children at imminent risk of homelessness. The Program supports innovative approaches for the delivery of outreach, health services, and referral for homeless children and at-risk children. The needs of these children are addressed within the context of prevention assessment of primary care needs and the provision of comprehensive primary care services.

When the HCHC program was originally conceived, it was assumed that most HCH grantees were primarily treating single adults. This has changed considerably since the HCHC program has begun. In calendar year (CY) 2001, the 10 HCHC grantees treated 19,00 patients, nearly 90 percent ages 19 or below. These children, however, represent fewer than one fifth of the 94,000 homeless children and adolescents receiving care from HCH grantees. In fact, almost a third of all HCH grantees have patient populations which include a significant number of children. To acknowledge and support this fact, the BPHC has chosen to broaden the focus on homeless children and adolescents to encompass all HCH grantee organizations.

Program Successes

The HCH program has garnered a number of successes during its fifteen years of providing assistance. HCH program grantees have developed innovative networks and collaborations that are successfully maximizing both the quality and number of services they provide. Additionally, these linkages are improving the delivery of comprehensive care by enhancing the diversification of services made available to homeless clients.

One of the reasons for the success of the HCH program is its flexibility. A variety of community-based organizations support HCH activities. Nearly half of the programs are sponsored by Federally-funded community and migrant health centers; the remaining programs are supported by public health departments, hospitals, community coalitions, and other community- based groups. Each individual program is free to determine which service delivery system or combination of systems is appropriate for the people it serves. The diversity in needs among homeless persons in various communities, and the variety among local service delivery systems, has spawned a diversity in HCH program models. Programs provide services in a variety of different settings, including stable clinic sites, shelter-based clinics, and mobile units. In addition, they take health care services to locations where homeless individuals are found, such as streets, parks, and soup kitchens.

Program Clients

The following section offers a brief snapshot of HCH program clients, using the most recent program data collected by the Bureau of Primary Health Care for Calendar Year 2001.

- Nearly 500,000 men, women, and children were served by HCH providers.

- The majority of clients (60%) were male; 40% were female.

- Clients between the ages of 20 and 44 represented the largest portion of consumers served by HCH programs (57%), followed by individuals between the ages of 45 and 64 (23%), children between the ages of 0 to 14 accounted for 13%, and teenagers between the ages of 15 and 19 were 5%. Although homeless persons over 65 continue to comprise merely 2% of clients served, the upwards shift of 3% in the 45-64 age category from 1999 may begin showing up in the over 65 category in future years.

- 62% of homeless clients were minorities:

  African Americans - 40%
  Hispanic - 17.5%
  Asian/Pacific Islander - 2%
  Native Hawaiian - less than 1%
  Other Pacific Islander - less than 1%
  Native American/Alaskan Native - 2%

- 40% of clients seen lived in shelters; 12% lived on the street. The remainder lived in transitional housing, were doubled up with family or acquaintances, or were in some other type of living arrangement.

- The majority (73%) of homeless clients had no medical care resources (up 3% from 1999). Of the remaining clients who had some type of insurance resource, 20% were Medicaid eligible (although not necessarily enrolled); 2% were Medicare eligible; 1% had private insurance; and 4% received some other type of public insurance.

- 92% of homeless clients (where income is known) were living at 100% or below the Federal poverty level.

As the health care and social service needs of homeless people have become more complex, Health Care for the Homeless programs continuously strive to create new approaches to reach and care for their clients. The following section, Part 2, details how each of the 154 HCH grantees deliver care to their clients, and identifies other subcontracting and collaborating organizations that are critical to ensuring quality in the continuum of care each patient receives.